OMB No. 0938-1378
Expires:7/31/2024

MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?
People with Medicare who want to join a Medicare Prescription Drug Plan

To join a plan, you must:
- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Prescription Drug Plan, you must also have either, or both:
- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?
You can join a plan:
- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?
- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1.The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:
- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?
Send your completed and signed form to:

Verda Health Plan of Texas
Attn: Enrollment Dept.
P.O. Box 105213
Jefferson City, MO 65110

Once they process your request to join, they'll contact you.

How do I get help with this form?
Call Verda Health Plan of Texas at 1-888-256-5123. TTY users can call 711.
Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Verda Health Plan of Texas al 1-888-256-5123/TTP 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness
- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Verda Health Plan of Texas

P.O. Box 105213
Jefferson City, MO 65110
Member Service #: 1-888-256-5123

Section 1 – All fields on this page are mandatory (unless marked as optional)

Choose the plan you want to enroll in:

☐ Verda Noble Care Plan (HMO) – 001	☐ Verda Noble Chronic Care Plan (HMO C-SNP)-002
$0, per month	$0, per month
Fort Bend, Harris, and Montgomery County	Fort Bend, Harris, and Montgomery County

First Name: Last Name: Optional: Middle Initial:

Date of birth: (MM/DD/YYYY) (__ __/__ __/ ___ ___ ___ __)	Sex: ☐ M ☐ F	Phone Number: ( )	Alternative Phone Number: ( )

Permanent Residence Street address (Don't enter PO Box):

City: State: Zip code: County:

Mailing address, if different from your permanent address (PO Box allowed):

City: State: Zip code:

Your Medicare Information

Please take your Red, White and Blue Medicare card to complete this section.	Name (as it appears on your Medicare card) ______________________________
•Fill this information as it appears on your Medicare card. -OR- •Attached a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Medicare Number: __ __ __ __- __ __- __ __ __ __ HOSPITAL (Part A): __ __/ __ __/ __ __ __ __ MEDICAL (Part B): __ __/ __ __/ __ __ __ __ You must have Medicare Part A and Part B to join a Medicare Advantage Plan

Answer these important questions:

1. Will you have other prescription drug coverage (such as VA, TRICARE) in addition to Verda Health Plan of Texas? ☐ Yes ☐ No

Name of other coverage: ____________________ Member number for this coverage: ____________________ Group number for this coverage: ____________________

2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes", please provide the following information: Medicaid ID #: ______________________________

3. Do you have Cardiovascular Disorder, Congestive Heart Failure (CHF) and or Diabetes? ☐ Yes ☐ No

Important: Read and Sign Below:

•I must keep both Hospital (Part A) and Medical (Part B) to stay in Verda Health Plan of Texas.

•By joining this Medicare Advantage, I acknowledge that Verda Health Plan of Texas will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

•I understand that I can be enrolled in only one MA Plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA Plan (exceptions apply for MA PFFS, MA MSA plans).

•I understand that when my Verda Health Plan of Texas coverage begins, I must get all of my medical and prescription drug benefits from Verda Health Plan of Texas. Benefits and services provided by Verda Health Plan of Texas and contained in my Verda Health Plan of Texas "Evidence of Coverage" or "Member Handbook" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Verda Health Plan of Texas will pay for benefits or services that are not covered.

•The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

•I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this Enrollment form (as described above), certifies that:

1)This person is authorized under State law to complete this enrollment, and
2)Documentation of this authority is available upon request by Medicare.

Signature:	**Today's Date:**

<u>If you are the authorized representative, sign above and fill out these fields:</u>

Name: ________________________________ Address: ________________________________

Phone Number: ______________________________ Relationship to enrollee: ________________________________

Section 2 – All fields on this page are optional

Answering these questions is your choice. You cannot be denied coverage because you don't fill them out.

1) Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a

☐ Yes, Puerto Rican ☐ Yes, Cuban

☐ Yes, another Hispanic, Latino/a, Spanish origin ☐ **I chose not to answer.**

2) **What's your race? Select all that apply.**

☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American

☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro

☐ Japanese ☐ Korean ☐ Native Hawaiian

☐ Other Asian ☐ Other Pacific Islander ☐ Samoan

☐ Vietnamese ☐ White ☐ **I chose not to answer.**

3) **Select an option below if you want us to send you information in an accessible format:**

☐ Braille ☐ Large print ☐ Audio CD

Please contact Verda Health Plan of Texas at 1-888-256-5123 (TTY users should call 711) if you need information in an accessible format or language other than what is listed above. Our office hours are from 8 AM – 8 PM,7 days a week from October 1 to March 31 and from 8 AM – 8 PM Monday thru Friday April 1 to Sept 30

4) I want to get materials via email. ☐ Yes ☐ No

If " yes" please provide your email **Email:** ____________________________________

5) Do you work? ☐ Yes ☐ No

6) Does your spouse work? ☐ Yes ☐ No

Choose a Primary Care Physician (PCP) : ____

PCP IPA/Medical Group Name: ______________________ **PCP ID #:** ______________________

Are you a current patient? ☐ Yes ☐ No

Paying your Plan Premiums

You can pay your monthly premiums (including any late enrollment penalties you currently have or owe) by mail every month. **You can also pay the premium each month by automatically deducting from your Social Security or Railroad Retirement Board (RRB) benefit.**

If you must pay a Part D Income Related Monthly Adjustment Amount (IRMAA), you must pay this additional amount in addition to your plan premium. Usually, the amount is deducted from your Social Security benefit, or you may receive a bill from Medicare (or the RRB). DO NOT pay the Part D IRMAA to Verda Health Plan of Texas.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option.

☐**Get a Bill**

☐**Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check**

I get my monthly benefits from: ☐ Social Security ☐ RRD

The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Agent / Broker Information

☐IEP/ICEP ☐ AEP ☐ OEP ☐ SEP(type) __________

Name of Agent / Broker (If assisted in enrollment**):** ____________________________

Agency Name (if applicable**):** ____

Agent / Broker Signature (if assisted in enrollment): ____________________________

National Producer Number (NPN): ____________________ **Application Receive Date:** ______________

Proposed Effective Date: ____________________(Required)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Applicant Name: ______________________________

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare. (IEP/ICEP)

☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan, or I recently moved, and this plan is a new option for me. I moved on (insert date) _________________________. (SEP)

☐ I recently was released from incarceration. I was released on (insert date) ____________.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) __________________.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____________________________. (SEP)

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help,had a change in the level of Extra Help, or lost Extra Help) on (insert date) _______________________.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. (SEP)

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) __________________________.

☐ I recently left a PACE program on (insert date) ______________________________.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ____________________________.

☐ I am leaving employer or union coverage on (insert date) ______________________.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (insert date) _________________________.

☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) ________________________________. (SEP)

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster. Please specify the following:
Weather-related emergency or major disaster: __________________ Election period missed: ____________

If none of these statements applies to you or you're not sure, please contact Verda Health Plan of Texas at 1-888-256-5123, TTY users should call 711 to see if you are eligible to enroll. Our office hours are from 8a – 8p, 7 days a week from Oct 1 to Mar 31 and from 8a – 8p Monday through Friday Apr 1 to Sep 30.

Pre-Enrollment Qualification Assessment Form

To enroll into Verda Health Plan of Texas Chronic Condition Special Needs Plan, we are required to confirm your diagnosis of a qualifying health condition. When this form is completed and submitted along with an enrollment application, you will be enrolled into Verda Health Plan of Texas CSNP Plan. We will attempt to verify your chronic condition(s) with your provider during the first month of enrollment. If we are unable to verify your chronic condition(s), we are required to disenroll you from our Special Needs Plan.

Your Information

Full Name: ______________________________ Date: ____________

Last *First* *M.I.*

Gender: ☐ Male ☐ Female DOB: ____________

Chronic Condition Questions

If any of the following are checked, the enrollee pre-qualifies.
Have you ever been told by a physician that you have any of the following conditions:

☐ Diabetes Mellitus (High Blood Sugar)

☐ Chronic Heart Failure (CHF)

☐ Cardiovascular Disorders – must be one of the following:

- Cardiac Arrhythmias
- Coronary Artery Disease
- Peripheral Vascular Disease
- Chronic Venous Thromboembolic Disorder

Additional Questions

1. Do you take any medications for the conditions listed above? ☐ Yes ☐ No
2. Are you now or have you ever taken Metformin or Insulin Injection? ☐ Yes ☐ No

Below, Please check all medications you have ever taken:

☐ Humalog	☐ Novolog	☐ Humulin	☐ Novolin	☐ Lantus	☐ Toujeo
☐ Tresiba	☐ Metformin	☐ Glipizide	☐ Glimepiride	☐ Pioglitazone (Actos)	
☐ Trulicity	☐ Januvia	☐ Janumet	☐ Tradjenta	☐ Farxiga	☐ Jardiance
☐ Captopril	☐ Enalapril	☐ Fosinopril	☐ Losartan	☐ Valsartan	☐ Metoprolol
☐ Digoxin	☐ Coumadin	☐ Amlodipine	☐ Chlorothiazide	☐ Furosemide	☐ Eplerenone
☐ Lisinopril	☐ Ramipril	☐ Carvedilol	☐ Hydralazine & isosorbide dinitrate	☐ Clopidogrel	☐ HCTZ

Others:

☐	☐	☐
☐	☐	☐

Primary Care Physicians

Provider Name: ______________________ Address: ____

Phone Number: ______________________ Fax Number: ____

Specialist

Specialist Name: ______________________ Address: ____

Phone Number: ______________________ Fax Number: ____

Disclaimer and Signature

Authorization for Disclosure of Health Information to verify Chronic Condition(s):

I hereby authorize the disclosure of my health information by the providers listed above to Verda Healthcare in order to verify that I have been diagnosed with a chronic condition which qualifies me for enrollment in a Verda Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

Note: *Information disclosed as a result of this authorization will be protected by Verda Healthcare in accordance with applicable state and federal laws and requirements.*

Enrollee Signature: ____ Date: ______________________

Verda Health Plan of Texas

Coordination of Care Form

Member Information

Full Name: ____ Date: ______________

Last *First* *M.I.*

Date of Birth: ________________________ Phone: ________________________________

Emergency Contact: __________ Phone Number ________________ Relationship ___________

Preferred Spoken Language: ☐ English ☐ Spanish ☐ Cantonese ☐ Korean ☐ Mandarin ☐ Tagalog ☐ Vietnamese ☐ Other

Primary Care Physician / Medical Group Information

PCP with Verda Healthcare

____

Same PCP prior enrolling to Verda? YES ☐ NO ☐

Medical Group / IPA with Verda Healthcare

____

Same Medical Group / IPA prior enrolling to Verda? YES ☐ NO ☐

If No, who is the current PCP and Medical Group? ____________________________________

Continuity Of Care and Services

Please let us know if you have any of the following issues that apply to you, we will have a Care Coordination Team member contact you to assist with the transition of services:

☐ Immediate Needs – Food, Homeless, Cannot Afford Medications

☐ Middle of Treatment – Chemotherapy / Dialysis / Home Health

☐ Durable Medical Equipment – ☐ Own ☐ Rental

☐ Currently Hospitalized

☐ Planned Surgery in the coming months

If **Rental, who is** the DME Company?

Name: _______________________________ Phone: _______________________________

☐ Bath Chair	☐ Commode	☐ Hospital Bed	☐ Toilet seats
☐ Cane	☐ C-PAP machine	☐ Oxygen	☐ Walker
☐ Catheters	☐ Diapers	☐ Pressure Mattress	☐ Wheelchair

☐ Other_____________________________

☐ Other____

Medications

Please provide a list of medications that require Prior Authorization or not on our formulary, our Care Coordination Team member will contact you to assist with the prescription transition fills:

Medication Name: ___________________________ Dosage: ___________________________

Medication Name ___________________________ Dosage: ___________________________